

MaineCare Services

An Office of the Department of Health and Human Services

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May 5, 2009

TO: Interested Parties

FROM: Anthony Marple, Director, MaineCare Services

SUBJECT: Final Rule: MaineCare Benefits Manual, chapters II & III, Section 45, Hospital Services

This adopted rlue adjusts hospital reimbursement methodology. Chapter III, section 45 clarifies and revises reporting requirements and defines the MaineCare Supplemental Data Form, and it clarifies that crossover payments are made to the extent required by CMS. Chapter III also increases the supplemental pool to be distributed among noncritical access hospitals from approximately \$36 to \$45 million and counts 50% of the psychiatric discharges when distributing the pool: increases the pool for the critical access hospital from \$2 to 3.5 million; increases the PIP cap to approximately 81%; creates a separate section for Hospitals Reclassified to a Wage Area Outside Maine by the Medicare Geographic Classification Review Board and limits reimbursement under that section to hospitals reclassied prior to the effective date of the rule; revises sections 45.03, 45.04, 45.05 and 45.06 to separate the calculation of the PIP from the calculation of the Department's obligation at settlement; establishes base discharge rates for acute care non-critical access hospitals (Franklin Memorial hospital services rate was changed due to a revision made to the base year report); and removes outdated material. Several provisions have a retroactive effective date of 10/1/08. Pursuant to 22 M.R.S.A. §42(8), the Department is authorized to adopt rules with retroactive application when, as here, it is necessary to maximize available revenue sources, and there is no adverse financial impact on any MaineCare provider or member.

These rules permanently adopt emergency rules, effective February 21, 2009, that reduce non-emergency room outpatient hospital-based physician reimbursement to 46.21% of costs, which is the closest to 70% of the Medicare fee schedule that the Department could fund with the resources used for physician reimbursement, as adjusted by the Supplemental Budget, which reduced reimbursement by \$1,947,490 of state dollars. A percentage of costs is being used to calculate 70% of the Medicare fee schedule absent claims—based data. Prospective Interim Payments (PIP) will be lowered in an amount corresponding to the anticipated hospital-based physician payment reimbursements, which are paid separately and not paid as part of PIP. Permanent adoption of this methodology change will be contingent upon approval by the U.S. Centers for Medicare and Medicaid Services (CMS).

Two proposed changes were withdrawn as a result of comments and legislative action. The provision for hospitals to report professional services on a CMS 1500 form separate from facility fees was withdrawn due to a moratorium enacted by Congress. Also, the reimbursement of non-emergency room hospital-based physician at 70% of the Medicare

fee schedule was withdrawn due to contrary pending legislation in the 1st session of the 124th Legislature. Finally, two technical changes update web links in Chapter II, Sections 45.11 and 45.12.

A public hearing was held on April 13, 2009. The comment deadline was April 23, 2009.

Rules and related rulemaking documents may be reviewed at and printed from the Office of MaineCare Services website at

http://www.maine.gov/dhhs/oms/rules/provider_rules_policies.html or, for a fee, interested parties may request a paper copy of rules by calling 207-287-9368. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 1-800-423-4331.

A copy of the public comments and Department responses can be viewed at and printed from the Office of MaineCare Services website or obtained by calling 207-287-9368 or TTY (207) 287-1828 or 1-800-423-4331.

If you have any questions regarding the policy, please contact your provider Relations Specialist at 624-7539, option 8 or 1-800-321-5557, extension option 8 or TTY: (207) 287-1828 or 1-800-423-4331.

Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services. Office of MaineCare Services

CHAPTER NUMBER AND TITLE: MaineCare Benefits Manual, Chapters II and III, Section 45, **Hospital Services**

ADOPTED RULE NUMBER: 2009-196

CONCISE SUMMARY: This adopted rule adjusts hospital reimbursement methodology. Chapter III, Section 45 clarifies and revises reporting requirements and defines the MaineCare Supplemental Data Form, and clarifies that cross-over payments are made to the extent required by CMS. Chapter III also increases the supplemental pool to be distributed among non-critical access hospitals from approximately \$36 to \$45 million and counts 50% of the psychiatric discharges when distributing the pool; increases the pool for the critical access hospital from \$2 to 3.5 million; increases the PIP cap to approximately 81%; creates a separate section for Hospitals Reclassified to a Wage Area Outside Maine by the Medicare Geographic Classification Review Board and limits reimbursement under that section to hospitals reclassified prior to the effective date of the rule; revises sections 45.03, 45.04, 45.05 and 45.06 to separate the calculation of the PIP from the calculation of the Department's obligation at settlement: establishes base discharge rates for acute care non-critical access hospitals (Franklin Memorial hospital services rate was changed due to a revision made to the base year report); and removes outdated material. Several provisions have a retroactive effective date of 10/1/08. Pursuant to 22 M.R.S.A. §42(8), the Department is authorized to adopt rules with retroactive application when, as here, it is necessary to maximize available revenue sources, and there is no adverse financial impact on any MaineCare provider or member.

These rules permanently adopt emergency rules, effective February 21, 2009, that reduce hospital-based physician reimbursement to 46.21% of costs, which is the closest to 70% of the Medicare fee schedule that the Department could fund with the resources used for physician reimbursement, as adjusted by the Supplemental Budget, which reduced reimbursement by \$1,947,490 of state dollars. A percentage of costs is being used to calculate 70% of the Medicare fee schedule absent claims—based data. Prospective Interim Payments (PIP) will be lowered in an amount corresponding to the anticipated hospital-based physician payment reimbursement, which are paid separately and not paid as part of PIP. Permanent adoption of this methodology change will be contingent upon approval by the U.S. Center for Medicare and Medicaid Services (CMS).

Two proposed changes were withdrawn as a result of comments and legislative action. The provision for hospitals to report professional services on a CMS 1500 form separate from facility fees was withdrawn due to a moratorium enacted by Congress. Also, the reimbursement of non-emergency room hospitalbased physicians at 70% of the Medicare fee schedule was withdrawn due to contrary pending legislation in the 1st session of the 124th Legislature. Two links were updated in Chapter II, Section 45.11 and Section 45.12.

This rulemaking does not adversely impact counties or municipalities, and it does not adversely impact small businesses of twenty (20) or fewer employees because the service affected by the rate reduction is not provided by small businesses.

See http://www.maine.gov/dhhs/oms/rules/provider rules policies.html for rules and related rulemaking documents.

EFFECTIVE DATE: May 23, 2009 **AGENCY CONTACT PERSON:** Robert Kohl, Health Planner

AGENCY NAME: Division of Policy and Performance

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10-144 Chapter 101 DEPARTMENT OF HEALTH AND HUMAN SERVICES MAINECARE BENEFITS MANUAL CHAPTER II

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45.11 BILLING INSTRUCTIONS (cont.)

- B. For all services provided on or after September 1, 2007 by primary care practices that are considered Medicare provider based entities, providers must bill in accordance with the Department's billing requirements set forth in "Billing Instructions: Claim Form CMS-1500" or successor instructions.
- C. For all outpatient services, other than those identified in B above, providers may bill using either the UB-92 or successor form or the CMS-1500, in accordance with the applicable MaineCare billing instructions.
- D Providers should request reimbursement for all services provided on the same day on the same claim form.
- E. Only providers that qualify as "provider based" entities under 42 CFR 413.65 may bill under this Section of the MaineCare Benefits Manual.

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F. Copies of MaineCare billing instructions may be downloaded at http://www.maine.gov/dhhs/oms/providerfiles/billing_instructions.html

45.12 **REPORTING REQUIREMENTS**

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Hospitals must submit a quarterly list of NDC codes for claims submitted on or after July 1, 2008 for the top 20 drugs on a list maintained by CMS. Hospitals eligible to purchase these drugs through Section 340B of the Public Health Service Act (referred to as 340 B hospitals) are exempt from this requirement. The list of Medicaid Top 20 Physician-Administered Multiple Source drugs is at

http://www.cms.hhs.gov/Reimbursement/15 PhysicianAdministeredDrugs.asp

The quarterly report must be submitted within three months (or the first day thereafter) of the end of the calendar quarter in which the claim is filed. (e.g., Jan 1, 2009 for claims filed July 1, 2008 – Sep. 30, 2008) in accordance with the Department's billing instructions. The Department has determined that a failure to comply with this reporting requirement is a sanction, as defined in MBM, Chapter I, Section I, 1.19.

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INTRODUCTION

MaineCare recognizes five different types of hospitals for the purpose of reimbursement, all of which are detailed below. MaineCare uses a different payment methodology for each type of facility. MaineCare reimburses hospitals in the following ways:

- 1) **Acute Care Non-Critical Access Hospitals** are reimbursed with a rate per discharge for inpatient services, and a percentage of cost basis for outpatient services;
- 2) **Acute Care Critical Access Hospitals** are reimbursed at a percentage of cost basis for inpatient and outpatient services;
- 3) **State Owned Psychiatric Hospitals** are reimbursed on a cost basis for inpatient and outpatient services;
- 4) **Private Psychiatric Hospitals** are reimbursed at a percentage of charge basis for inpatient services and at a percentage of cost basis for outpatient services; and
- 5) Hospitals Reclassified to a Wage Area Outside Maine by the Medicare Geographic Classification Review Board are reimbursed at a percentage of cost basis for inpatient and outpatient services;

All hospitals, regardless of type, are paid estimated prospective, periodic interim payments (PIP) that are then "settled" compared to actual discharges, costs incurred and/or charges during the State fiscal year, as applicable. For most hospitals, at least part of this interim settlement is based on the As-Filed Medicare Cost Report submitted by the hospital. A second, final settlement occurs using the Medicare Final Cost Report, issued by the Medicare fiscal intermediary. Some hospitals with high uncompensated costs will also receive a disproportionate share (DSH) payment.

45.01 **DEFINITIONS**

- 45.01-1 **Acute Care Critical Access Hospital** is a hospital licensed by the Department of Health and Human Services (DHHS or "the Department") as a critical access hospital that is being reimbursed as a critical access hospital by Medicare.
- 45.01-2 **Acute Care Non-Critical Access Hospital** is a hospital licensed by the Department as an acute care hospital that is not being reimbursed as a critical access hospital by Medicare.
- 45.01-3 **As-Filed Medicare Cost Report** means the cost report that the hospital files with the Medicare fiscal intermediary and with MaineCare, utilizing the CMS Medicare Cost Report form. In order for an As-Filed Medicare Cost Report to be accepted by MaineCare, hospitals must complete all information in the sections relevant to Title XIX, whether or not required by CMS.

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45.01 **DEFINITIONS** (cont.)

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- **Discharge** is when a member is formally released from the hospital, transferred from one hospital to another, or dies in the hospital. For purposes of this Section, a member is not considered discharged if he or she is transferred to any different location or different unit, such as a rehab unit, in the same hospital, or is readmitted to the same hospital on the same day.
- 45.01-5 **Distinct Psychiatric Unit** is a unit within an acute care non-critical access hospital that specializes in the delivery of inpatient psychiatric services. The unit must be reimbursed as a distinct psychiatric unit as a sub provider on the Medicare cost report or must be comprised of beds reserved for use for involuntary commitments under the terms of a contract with the Department of Health and Human Services. The claim must also be distinguishable as representing a discharge from a distinct psychiatric unit in the MaineCare claims processing system.
- 45.01-6 **Final Cost Settlement Report** is the report issued by the DHHS Office of Audit that contains the final settlement calculation and settlement amount due to or due from the hospital. This Report utilizes the hospital cost data from the Medicare Final Cost Report.
- 45.01-7 Hospital Reclassified to a Wage Area Outside Maine by the Medicare Geographic Classification Review Board (MGCRB) is a hospital that has been reclassified by the MGCRB. The MGCRB decides on requests of hospitals that are reimbursed under the Prospective Payment System (PPS) for the purposes of Medicare for reclassification to another area (urban or in some cases rural) for the purposes of receiving a higher wage index. (See section 1886 of the Social Security Act, 42 U.S.C. § 1395ww). Further information can be found at http://www.cms.hhs.gov/MGCRB/.
- 45.01-8 **Institution for Mental Disease** (IMD) means an institution primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. This includes medical attention, nursing care, and related services.
- 45.01-9 **Interim Cost Settlement Report** is the report issued by the DHHS Office of Audit that contains the settlement calculation and amount due to or due from the hospital. This report utilizes the hospital cost data from the As-Filed Medicare Cost Report.
- 45.01-10 **Low Income Utilization Rate** for a hospital means the sum of:
 - 1) the fraction (expressed as a percentage)
 - a) the numerator of which is the sum (for a period) of (i) the total revenues paid the hospital for patient services under a State plan, and (ii) the amount of the cash subsidies for patient services received directly from State and local governments, and

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45.01 **DEFINITIONS** (cont.)

- b) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and
- 2) the fraction (expressed as a percentage)
 - a) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in clause a) (ii) of subparagraph 1) in the period reasonably attributable to inpatient hospital services, this numerator shall not include contractual allowances and discounts (other than for indigent patients not eligible for MaineCare), and
 - b) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

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- 45.01-11 **MaineCare Supplemental Data Form** is a form submitted by hospitals on a template provided by the department which contains information supplemental to the Medicare Cost Report necessary for computing the Prospective Interim Payment, including, but not limited to, data pertaining to hospital-based physicians, lab and radiology claims and third party payments.
- 45.01-12 **MaineCare Paid Claims History** is a summary of all claims billed by the hospital to MaineCare for MaineCare eligible members that have been processed and accepted for payment by MaineCare.
- 45.01-13 **MaineCare Utilization Rate (MUR)** means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for MaineCare and the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term "inpatient days" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual remains in the hospital for lack of suitable placement elsewhere. The period used to determine the MUR is the Payment Year, as defined below.
- 45.01-14 **Medicare Final Cost Report** means the Report issued by the Medicare fiscal intermediary and issued to the hospital and to MaineCare.
- 45.01-15 **Payment Year,** for purposes of Disproportionate Share (DSH) eligibility calculations, means a year commencing on or after October 1st. However, if a hospital has a fiscal year that commences between September 20 and September 30, then its fiscal year shall be deemed to be a fiscal year commencing October 1st of the same

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45.01	DEFIN	NITIONS (cont.)	
		calendar year. For example, if a hospital's fiscal year er year shall be deemed to be a fiscal year commencing O	
Effective 5/23/09	45.01-16	Private Psychiatric Hospital is a hospital that is proposed psychiatric services for the diagnosis, treatment, and illness and is privately owned. The facility must be lice by the Department of Health and Human Services. A poknown as an institution for mental disease.	care of persons with mental ensed as a psychiatric hospital
Effective 5/23/09	45.01-17	Prospective Interim Payment (PIP) is the prospective hospitals. State owned hospitals receive quarterly prosp All other hospitals receive weekly PIP payments. These only a portion of the amount due the hospital; other lum hospitals throughout the year are not Prospective Interindesignated.	pective interim payments. e payments may represent ap sum payments made to
Effective 5/23/09	45.01-18	Provider's Fiscal Year is the twelve (12) month period accounting period.	d used by a hospital as an
	45.01-19	State Fiscal Year is the twelve (12) month period used accounting period which begins July 1 and ends June 30 1, 2000, and ends June 30, 2001).	
Effective 5/23/09	45.01-20	State Owned Psychiatric Hospital is a hospital that is providing psychiatric services for the diagnosis, treatmental illness and is owned and operated by the State of licensed as a psychiatric hospital by the Department of psychiatric hospital may also be known as an institution	ent, and care of persons with f Maine. The facility must be Health and Human Services. A
Effective 5/23/09	45.01-21	Transfer means a member is moved from one hospital MaineCare will not reimburse for more than two dischastor a member transferring between multiple hospitals.	

45.02 **GENERAL PROVISIONS**

45.02-1 Inflation

For purposes of determining inflation, unless otherwise specified, the economic trend factor from the most recent edition of the "Health Care Cost Review" from Global Insight is used.

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45.02 **GENERAL PROVISIONS** (Cont'd)

45.02-2 Third Party Liability (TPL)

When a member is admitted to a hospital, it is the hospital's responsibility to identify all coverage available and perform all procedural requirements of that identified coverage to assure proper reimbursement. The Department will remove claims data from the MaineCare paid claims history when the TPL reimbursement for that claim is equal to or exceeds MaineCare reimbursement. Please see Chapter I Section 1.07 of the MaineCare Benefits Manual for detailed definitions applicable to Third Party Liability. Providers must adhere to the procedures outlined in that Section. Any MaineCare claims data submitted by a hospital may only be withdrawn within one hundred twenty (120) days of the date of the remittance statement.

45.02-3 Interim and Final Cost Settlements

At interim and final settlements, the hospital will reimburse the Department for any overpayments within thirty (30) days of receipt of the settlement report, or the

Department will reimburse the amount of any underpayment to the hospital. Each Interim and Final Cost Settlement Report must be treated separately for purposes of remitting checks for overpayment and underpayment. If no payment is received within thirty (30) days, the Department may offset prospective interim payments, if permitted by federal and state law. Any caps imposed on Prospective Interim Payments (PIPs) are not applicable to the determination of settlement amounts.

The final settlement will not be performed until the Department receives the Medicare Final Cost Report. If the Medicare Final Cost Report has been received by the Department prior to the issuance of the Interim Cost Settlement Report, the Department will issue only a Final Cost Settlement Report.

Pursuant to PL 2007, P & S Law, Chapter 19, and subject to CMS approval, when carrying out final and interim settlements of payments, the Department shall pay all final settlements for hospital fiscal years 2003 and earlier prior to paying interim settlements for services for hospital fiscal years 2005 and later. This does not limit the Department's authority to:

- 1. Make ongoing MaineCare payments for services being rendered during the current fiscal year; or
- 2. Provide partial settlements for hospital fiscal years 2004 and later to certain hospitals in need of such relief in order to relieve financial hardship. Financial hardship is determined by the Department and includes consideration of such

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45.02 **GENERAL PROVISIONS** (Cont'd)

factors as a high settlement amount due as a percent of total patient revenue, significant negative operating margins and/or negative cash flow as reflected on audited financial statements.

The provider must submit a written request for a hardship waiver to the DHHS Commissioner, the later of 60 days from the effective date of these rules or 60 days from the due date for the hospital's MaineCare cost report. All supporting documentation must be submitted with the request.

The Department will not make a determination of financial hardship until resources are available to issue interim or final hospital audit settlements. The Department may request additional information to support the provider's claim of financial hardship before making a determination.

45.02-4 Crossover Payments

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MaineCare does not reimburse for Medicare crossover payments, except to the extent required by CMS (See 42 U.S.C. 1396a(a)(10)(E)(i) and 42 U.S.C. 1396d(p)(3)).

45.02-5 Reporting and Payment Requirements

All Maine hospitals are required to submit an As-Filed Medicare Cost Report, MaineCare Supplemental Data Form and additional documents as described below, within five (5) months of the end of the provider's fiscal year, as defined above, to the State of Maine Department of Health and Human Services, Office of Audit, 11 State House Station, Augusta, ME, 04333. Non-Maine (out-of-state) hospitals are not required to submit any cost reports.

Effective 5/23/09

A. As-Filed Medicare Cost Report and MaineCare Supplemental Data Forms

Maine hospitals are required to utilize the Medicare Cost Report forms including both Title XVIII and Title XIX work sheets for their As-Filed Medicare Cost Reports. Title XIX worksheets must include all MaineCare charge data available at the time of filing. The MaineCare Supplemental Data Form must also be provided on a template provided by the Department. All sections relevant to Title XIX must be completed, whether or not required by CMS.

B. Required Certifications and Signatures

All documents must bear original signatures. The administrator of the hospital must certify the As-Filed Medicare Cost Report by signing it. If someone other than facility staff prepares the return, the preparer must also sign the report.

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45.02 **GENERAL PROVISIONS** (Cont'd)

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The hospital shall also submit a copy of the MaineCare Supplemental Data Form electronically.

C. As-Filed Medicare Cost Report and MaineCare Supplemental Data Form Time Period

The As-Filed Medicare Cost Report and the MaineCare Supplemental Data Form shall cover the twelve (12) month period of each provider's fiscal year unless:

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1. a change in licensing category has become effective during a provider's fiscal year, (e.g., a hospital becomes designated as a critical access hospital) in which case the hospital must file two (2) versions of As-Filed Medicare Cost Report and the MaineCare Supplemental Data Form, one (1) for the part of the fiscal year under one licensing category and another for the part of the fiscal year under the second licensing category; or

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- 2. advance authorization to submit an As-Filed Medicare Cost Report and a MaineCare Supplemental Data Form for a lesser period has been granted in writing by the Director of the Office of Audit.
- D. Documentation Required to Be Filed With the As-Filed Medicare Cost Report

The Department requires that the following supporting documentation be submitted with the As-Filed Medicare Cost Report:

Note: [Cents are omitted in the preparation of all schedules except when inclusion is required to properly reflect per diem costs or rates.]

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- 1. Audited financial statements.
- 2. Worksheet reconciling financial statement revenue to the Worksheet C charges on the As-Filed Medicare Cost Report.
- 3. MaineCare Supplemental Data Form
- E. Payment Requirements in the Event of an Overpayment to the Hospital If a hospital determines from the As-Filed Medicare Cost Report that the hospital owes monies to the Department of Health and Human Services, a check equal to fifty percent (50%) of the amount owed to the Department must accompany the As-Filed Medicare Cost Report.

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45.02 **GENERAL PROVISIONS** (cont.)

If the Department does not receive a check with the As-Filed Medicare Cost Report, the Department may elect to suspend prospective payments, pursuant to State regulations and statutes, until the provider pays fifty percent (50%) of the money owed the Department.

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F. Consequences of Failing to File Complete and Adequate As-Filed Medicare Cost Report and MaineCare Supplemental Data Form

The Department has determined that failing to file an adequate, complete As-Filed Medicare Cost Report and MaineCare Supplemental Data Form, as determined by the Department, in a timely manner as required above is grounds for the Department to impose sanctions pursuant to the MaineCare Benefits Manual Chapter I, Section I.

The Office of Audit may reject any reports that do not comply with these regulations. In such cases, the Department shall deem the report incomplete until re-filed and in compliance.

G. Extensions

Hospitals must file all requests for extension of time to file an As-Filed Medicare Cost Report and/or MaineCare Supplemental Data Form in writing, and the Office of Audit must receive the request no less than fifteen (15) days prior to the due date. The hospital must clearly explain the reason for the request and specify the date by which the Office of Audit will receive the report.

The Office of Audit will not grant automatic extensions. The Director of the Office of Audit has the sole discretion to determine whether the request is for good cause based on the merits of each request. A "good cause" is one that supplies a substantial basis for the delay or an intervening action beyond the provider's control. Ignorance of the rule, inconvenience, or a Cost Report preparer engaged in other work will not be considered "good cause."

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45.02-6 **Data for PIP Calculation**

To calculate the PIP for a given state fiscal year the Department will use the most recent As-Filed Medicare Cost Report, and the MaineCare Supplemental data form filed by the hospital, to the extent these reports contain complete information, including but not limited to, the Title XIX section of the Medicare Cost Report and the MaineCare paid claims history to the extent that it is available. If they are not complete, the Department will use the most recent Cost Settlement Report. The Department will also review any additional data submitted by the deadline regarding

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45.02 **GENERAL PROVISIONS** (cont.)

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significant differences in costs that occurred after the year of the cost report. The Department's estimates of PIP will also reflect operational and/or policy revisions expected to result in substantive changes to services provided by hospitals.

The deadline for receipt of data related to the calculation of prospective interim payments, including estimated discharges, will be May 31 of the calendar year in which the state calculates the PIP.

45.03 ACUTE CARE NON-CRITICAL ACCESS HOSPITALS

45.03-1 **Department's Total Obligation to the Hospital**

Effective October 1, 2008, when approved by CMS, The Department of Health and Human Services' total annual obligation to a hospital will be the sum of MaineCare's obligation for the following: inpatient services + outpatient services (defined as including non-emergency hospital based physician services in section B below) + inpatient capital costs + inpatient hospital based physician costs, outpatient emergency room hospital based physician costs and direct graduate medical education costs + days awaiting placement in swing beds + Disproportionate Share Hospital (for eligible hospitals) and supplemental pool reimbursements.

Effective 5/23/09

A. Inpatient Services

1. **Inpatient**

Effective 5/23/09

Effective August 1, 2006, the Department will use the rates shown in Appendix A. These rates will be adjusted annually for inflation as described in 45.02-1 and according to the methodology in Appendix A.

2. **Distinct Psychiatric Unit**

If approved by CMS, the Department will reimburse hospitals for discharges from distinct psychiatric units at the discharge rate specified in Appendix A.

45.03 ACUTE CARE NON-CRITICAL ACCESS HOSPITALS

MaineCare will only reimburse at this rate when the member has spent the majority of his or her stay in the distinct unit. MaineCare will only reimburse for one (1) discharge for a single hospital for one (1) episode of care.

SECTION 45 HOSPITAL SERVICES **ESTABLISHED** 1/1/85 LAST UPDATED 5/23/09

45.03 ACUTE CARE NON-CRITICAL ACCESS HOSPITALS (cont)

These rates will be adjusted annually for inflation as described in 45.02-1.

3. **Supplemental Pool**

Effective 5/23/09

If approved by CMS, the Department will allocate a supplemental amount of forty-five million forty-six thousand one hundred twentysix dollars (\$45,046,126) for each state fiscal year among the privately owned and operated acute care non-critical access hospitals based on their relative share of inpatient MaineCare discharges, in the latest calendar year for which all hospitals have interim or final cost settlement reports, as compared to other acute care, non-critical access hospitals. Funds will be distributed semiannually, in even distributions in November and May.

This pool will be decreased by the amount a hospital would have received if that hospital was in the pool when the total pool amount was set and subsequently becomes an approved critical access hospital.

If a hospital is reclassified to a wage area outside Maine by the MGCRB and CMS approves that reimbursement category, the pool will be decreased by the amount of additional reimbursement that hospital will receive by virtue of changing reimbursement categories.

Each hospital in the pool will receive its relative share of this supplemental payment. The relative share is defined as a combination

- of two factors, each of which is used to distribute half the pool: the number of the MaineCare discharges, including 50% of
- those discharges from a distinct psychiatric unit, from that hospital in the latest calendar year for which all hospitals have interim or final cost settlement reports, divided by MaineCare discharges, including 50% of those discharges from a distinct psychiatric unit, for all non-critical access hospitals in that year; multiplied by the half of the total supplemental pool;
- the number of the MaineCare discharges, including 50% of those discharges from a distinct psychiatric unit, from that hospital in the latest calendar year for which all hospitals have interim or final cost settlement reports, multiplied by the cost per discharge; divided by MaineCare total cost of

Effective 5/23/09

SECTION 45 HOSPITAL SERVICES ESTABLISHED 1/1/85 LAST UPDATED 5/23/09

45.03 ACUTE CARE NON-CRITICAL ACCESS HOSPITALS (cont.)

the discharges, including 50% of those discharges from a distinct psychiatric unit, for all non-critical access hospitals in that year; multiplied by half of the total supplemental pool.

• In future years, data used to determine the relative share will relate to the latest state fiscal year for which there exists an As-Filed Medicare Cost Report or a Final Cost Settlement Report for all acute care non-critical access hospitals at the time the PIPs are set.

This amount will not be adjusted at the time of audit.

B. Outpatient Services

Effective 5/23/09

Effective October 1, 2008, the Department's total annual obligation to a hospital for outpatient services equals the lower of MaineCare outpatient costs or charges plus, non-emergency room outpatient hospital based physician costs and reduced by the applicable factor. For public non-critical access hospitals the applicable factor is eleven and sixty-five hundredths percent (11.65%). For other non-critical access hospitals the applicable factor is ten and three tenths percent (10.3%), Effective February 1, 2009, if approved by CMS, the non-emergency room hospital-based physician reimbursement will be 70.42% of costs.

Effective February 21, 2009, if approved by CMS, non-emergency room outpatient physician services will be reimbursed at 46.21% of costs.

MaineCare's share of clinical laboratory and radiology costs are added to this amount. The procedure codes and terminology of the Healthcare Common Procedure Coding System (HCPCS) (available at www.cms.hhs.gov) are used to establish MaineCare allowances for clinical laboratory and radiology services.

C. Other Components

Effective 5/23/09

MaineCare will reimburse its share of inpatient capital costs, inpatient hospital based physician and outpatient emergency room hospital based physician and all graduate medical education costs, and inpatient and outpatient third party liability.

SECTION 45	HOSPITAL SERVICES	ESTABLISHED 1/1/85
		LAST UPDATED 5/23/09

45.03 ACUTE CARE NON-CRITICAL ACCESS HOSPITALS (cont.)

Effective 5/23/09

- Effective February 1, 2009, if approved by CMS, the inpatient hospital-based physician and outpatient emergency room hospital-based physician reimbursement will be 78.51% of costs.
- Effective February 21, 2009, inpatient hospital-based physicians and outpatient emergency room hospital-based physicians will be reimbursed at 100% of MaineCare costs.

D. MaineCare Member Days Awaiting Placement at a Nursing Facility (NF)

Reimbursement will be made prospectively at the estimated statewide average rate per member day for NF services. The Department shall adopt the prospective statewide average rates per member day for NF services that are specified in the Principles of Reimbursement for Nursing Facilities, MaineCare Benefits Manual Chapter III, Section 67. The average statewide rate per member day shall be computed based on the simple average of the NF rate per member day for the applicable State fiscal year(s) and prorated at final settlement for a hospital's fiscal year.

45.03-2 **Prospective Interim Payment (PIP)**

Effective 5/23/09

The estimated Departmental total annual obligation will be calculated to determine the PIP payment using data as described in 45.02-5. When CMS approves, this sum will be reduced by the anticipated amount of reimbursement for Medicare approved provider based primary care physician services required to be billed on the CMS 1500 under Chapter II, Section 45 and those outpatient services the hospital has elected to bill on the CMS 1500. Effective October 1, 2008, if approved by CMS, the Department caps this payment at no less than eighty-one percent (81%) of the calculated amount of the total PIP for the current year but not less than the previous year's PIP. The PIP payment does not include DSH payments or the hospital's share of the supplemental pool as described below. The computed amounts are calculated as described 45.03-1.

45.03-3 Interim Prospective Interim Payment (PIP) Adjustment

The Department initiates an interim PIP adjustment of the prospective interim payment under very limited circumstances, including but not limited to, restructuring payment methodology as reflected in a state plan amendment; when a hospital "changes" categories (e.g., becomes designated critical access); or a hospital opens or closes resulting in a redistribution of patients among facilities.

Effective 5/23/09

45.03-4 Interim Cost Settlement

The Interim Cost Settlement is calculated using the same methodology as is used when calculating the PIP, except for the data sources. Inpatient calculations use discharges

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		LAST UPDATED 5/23/0)9

45.03 ACUTE CARE NON-CRITICAL ACCESS HOSPITALS (cont.)

and charges included in MaineCare paid claims history for the year for which settlement is being performed. Other calculations are based on the hospital's As-Filed Medicare Cost Report and MaineCare paid claims history for the year for which interim settlement is being performed. No cap imposed on a PIP will limit or otherwise affect the determination of settlement amounts.

Effective 5/23/09

45.03-5 Final Cost Settlement

The Department of Health and Human Services' final settlement with a hospital is calculated using the same methodology as is used when calculating the PIP, except for the data sources. Inpatient calculations use discharges and charges included in MaineCare paid claims history for the relevant year and the hospital's Medicare Final Cost Report. No cap imposed on a PIP will limit or otherwise affect the determination of settlement amounts.

Effective 5/23/09

45.04 ACUTE CARE CRITICAL ACCESS HOSPITALS (CAH)

All calculations made in relation to acute care critical access hospitals (CAH) must be made in accordance with the requirements for completion of the Medicare Cost Report and Generally Accepted Accounting Principles, except as stated below.

45.04-1 **Department's Total Obligation to the Hospital**

If approved by CMS, the Department of Health and Human Services' total annual obligation to the hospitals will be the sum of MaineCare's obligation of the following: inpatient services + outpatient services + days awaiting placement and in swing beds + hospital based physician + direct graduate medical education costs + Disproportionate Share Hospital (for eligible hospitals) and supplemental pool reimbursements (for eligible hospitals).

A. Inpatient Services

MaineCare will reimburse one hundred and seventeen percent (117%) of allowable costs.

B. Outpatient Services

 MaineCare will reimburse one hundred and seventeen percent (117%) of allowable costs, except for public non-state owned critical access hospitals, which will be reimbursed at 110% of allowable costs.

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45.04 ACUTE CARE CRITICAL ACCESS HOSPITALS (CAH) (Cont.)

Effective 5/23/09

- Non-emergency room outpatient hospital based physician costs will be reimbursed at 89.7% of costs through January 31, 2009.
- Effective February 1, 2009, if approved by CMS, the non-emergency room outpatient hospital-based physician costs will be reimbursed at 70.42% of costs.
- Effective February 21, 2009, the non-emergency room outpatient hospital-based physician services will be reimbursed at 46.21% of costs.

C. Supplemental Pool

Effective October 1, 2008, if approved by CMS, the Department will allocate the supplemental amount of three and a half million dollars (\$3,500,000) each state fiscal year among the privately owned and operated acute care critical access hospitals based on their relative share of total MaineCare payment as compared to other critical access hospitals. Each privately owned and operated hospital will receive its relative share of this supplemental payment.

The relative share is defined as the critical access hospital's MaineCare payment in state fiscal year 2004 divided by MaineCare payments made to all CAH hospitals in that year; multiplied by the total supplemental pool. This amount will not be adjusted at the time of audit.

D. MaineCare Member Days Awaiting Placement at a Nursing Facility

The Department will reimburse prospectively at the estimated statewide average rate per member day for NF services. The Department will reimburse at the prospective statewide average rates per member day for NF services that are specified in the Principles of Reimbursement for Nursing Facilities, MaineCare Benefits Manual Chapter III, Section 67. The Department shall compute the average statewide rate per member day based on the simple average of the NF rate per member day for the applicable State fiscal year(s) and prorated for a hospital's fiscal year.

Effective 5/23/09

E. Other Components

MaineCare will reimburse its share of inpatient hospital based physician, outpatient emergency room hospital based physicians and all graduate medical education costs.

• MaineCare's share of emergency room hospital based physician costs is reimbursed at 100% of cost.

SECTION Effective	ON 45	HOSPITAL SERVICES	ESTABLISHED 1/1/85 LAST UPDATED 5/23/09
5/23/09 45.04	ACUTE (CARE CRITICAL ACCESS HOSPITALS (CAH) (Co	ont.)
		 Effective February 1, 2009, if approve hospital based physician and outpatier based physician costs will be reimburs If approved by CMS, effective Februar based physician and outpatient emerge physician costs will be reimbursed at a second costs. 	nt emergency room hospital- sed at 78.51% of costs. ary 21, 2009 inpatient hospital- ency room hospital-based
	45.04-2	Prospective Interim Payment	
	PIPs will be reduced by the anticipated amount of reimbursement for Medic approved provider based primary care physician services as required to be the CMS 1500 under Chapter II, Section 45 and those outpatient services the has elected to bill on the CMS 1500. The PIP payment does not include DS payments or the hospital's share of the supplemental pool payments.		es as required to be billed on outpatient services the hospital does not include DSH
	45.04-3	PIP Adjustment	
		The Department initiates an interim PIP adjustment und including but not limited to, restructuring payment met plan amendment; when a hospital "changes" categories critical access); or a hospital opens or closes resulting i among facilities.	hodology as reflected in a state s (e.g., becomes designated
	45.04-4	Interim Cost Settlement	
		The Department calculates the Interim Cost Settlement methodology as is used when calculating the PIP, exceare the hospital's As-Filed Medicare Cost Report and Medicare for which interim settlement is being performed.	pt that the data sources used laineCare paid claims history
Effective 5/23/09	45.04-5	Final Cost Settlement	
Effective		The Department of Health and Human Services' calcul hospital using the same methodology as is used when ce the data sources used are the Medicare Final Cost Report history for the year for which settlement is being performance.	calculating the PIP, except that ort and MaineCare paid claims
5/23/09 45.05	MEDICA	LS RECLASSIFIED TO A WAGE AREA OUTSIDE RE GEOGRAPHIC CLASSIFICATION REVIEW B OBER 1, 2008.	
	hospitals, e	except that these hospitals are not eligible for payments from Section 45.04.	

SECTION 45 HOSPITAL SERVICES ESTABLISHED 1/1/85
Effective LAST UPDATED 5/23/09

5/23//09

45.06 PRIVATE PSYCHIATRIC HOSPITALS

45.06-1 Department's Total Annual Obligation to the Hospital

The Department of Health and Human Services' total annual obligation to the hospitals is the sum of MaineCare's obligation of the following: inpatient services + outpatient services + Disproportionate Share Hospital (for eligible hospitals).

A. Inpatient Services

The rate will be negotiated and becomes effective at the beginning of a hospital's fiscal year. The Department's total annual obligation shall be computed based on the hospital's negotiated rate.

The negotiated rate shall be between eighty-five percent (85%) and one hundred percent (100%) of the hospital's estimated inpatient charges, less third party liability. The hospital must notify the Department sixty (60) days prior to any increase in its charges.

If the hospital increases charges subsequent to the annual adjustment, the hospital and the Department will meet to consider the extent that the increase in charges will affect the amount paid by MaineCare and to negotiate the amount by which the previously negotiated percentage of charges must be adjusted to account for the impact. If the hospital commences any new MaineCare inpatient covered service, whether or not subject to Certificate of Need review, the parties will separately negotiate the percentage of charges to be paid by MaineCare for that service.

Special circumstances may arise during the course of a year that may warrant reconsideration and adjustment of the negotiated rate. These circumstances could include changes in psychiatric bed capacity or patient populations within the State that materially impact MaineCare or uncompensated care volume, extraordinary increases in charges, legislative deappropriation, MaineCare deficits that may result in decreased State funding, as well as other special circumstances that the parties cannot now foresee.

B. Outpatient Services

Effective 5/23/09

If approved by CMS, the Department's total annual obligation to the hospital will be one hundred and seventeen percent (117%) of allowable outpatient costs, determined from the most recent Interim Cost Settlement Report, inflated forward to the current State fiscal year.

HOSPITAL SERVICES

ESTABLISHED

1/1/85

SECTION 45

		LAST UPDATED 5/23/09
Effective 45.06	PRIVAT	TE PSYCHIATRIC HOSPITALS (cont.)
5/23/09	45.06-2	Prospective Interim Payment
		If approved by CMS, private psychiatric hospitals will be paid weekly prospective interim payments based on the Department's estimate of the total annual obligation to the hospital.
[45.06-3	Interim Cost Settlement
Effective		The Interim Cost Settlement with a hospital is calculated using the same methodology and negotiated percentage rate as is used when calculating the PIP, except that the data source used is the hospital's MaineCare paid claims history for the year for which Interim Cost Settlement is being performed. The hospital is required to submit its Medicare As-Filed Cost Report to the Department.
5/23/09	45.06-4	Final Cost Settlement
I		The Department's total annual obligation to a hospital will be computed using the same methodology as is used when calculating the PIP, except that the data sources used are the hospital's Medicare Final Cost Report submitted to DHHS and MaineCare paid claims history for the year for which settlement is being performed.
Effective		Note: The Department retains the right to reopen and modify cost settlement(s) affecting the timeframe from October 1, 2001 forward to assure consistency with the State Plan in effect for the time period covered by the settlement.
5/23/09 45.07	STATE	OWNED PSYCHIATRIC HOSPITALS
	State own	ned psychiatric hospitals are reimbursed as follows:
	45.07-1	Prospective Interim Payment
		State owned psychiatric hospitals receive quarterly prospective interim payments. The

A. Inpatient Services

The total MaineCare inpatient operating costs from the most recent Interim Cost Settlement Report inflated forward as described in Section 45.02-1 to the current State fiscal year.

MaineCare total annual obligation to the hospitals will be the sum of: MaineCare's obligation of the following: inpatient services + outpatient services + days awaiting placement + hospital based physician + direct graduate medical education costs + estimated DSH obligation. Other computed amounts are calculated as described below:

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		LAST UPDATED 5/23/09

45.07 STATE OWNED PSYCHIATRIC HOSPITALS (cont.)

B. Outpatient Services

MaineCare outpatient costs inflated to the current State fiscal year using the most recent Interim Cost Settlement Report.

C. MaineCare Member Days Awaiting Placement at a Nursing Facility

The Department will reimburse prospectively at the estimated statewide average rate per member day for NF services. The Department shall adopt the prospective statewide average rates per member day for NF services that are specified in the Principles of Reimbursement for Nursing Facilities, MaineCare Benefits Manual Chapter III, Section 67. The Department will compute the average statewide rate per member day based on the simple average of the NF rate per member day for the applicable State fiscal year(s) and prorated for a hospital's fiscal year.

D. Other Components

MaineCare's share of hospital based physician + graduate medical education costs are taken from the most recent hospital Interim Cost Settlement Report inflated to the current year.

Effective 5/23/09 45.07-2 **Interim PIP Adjustment**

The Department initiates an interim adjustment under very limited circumstances, including but not limited to, restructuring payment methodology as reflected in a state plan amendment; when a hospital "changes" categories (e.g., becomes designated critical access); or a hospital opens or closes resulting in a redistribution of patients among facilities.

Effective 45.07-3 **Interim Cost Settlement**

5/23/09

5/23/09

The Department calculates MaineCare Interim Cost Settlement with a hospital using the same methodology as is used when calculating the PIP, except that the data sources used are the hospital's As-Filed Medicare Cost Report and MaineCare paid claims history for the year for which interim settlement is being performed.

Effective 45.07-4 Final Cost Settlement

The Department calculates MaineCare's Final Cost Settlement with a hospital using the same methodology as is used when calculating the PIP, except that the data sources used are the Medicare Final Cost Report and MaineCare paid claims history for the year for which settlement is being performed. A final DSH adjustment will be made for eligible hospitals.

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Effective		LAST UPDATED 5/23/09
5/23/09		

45.08 **OUT-OF-STATE HOSPITALS**

The Department will reimburse out-of-state hospitals for inpatient and outpatient services based on

- 1. The MaineCare rate if applicable;
- 2. The lowest negotiated rate with a payor whose rate the hospital provider currently accepts;
- 3. The hospital provider's in-State Medicaid rate;
- 4. A percentage of charges; or
- 5. A rate specified in MaineCare's contract with the hospital provider.

Except as otherwise specifically provided in the agreement between MaineCare and the out-of-state hospital providers, out-of-state hospital providers must accept MaineCare reimbursement for inpatient services as payment in full for all services necessary to address the illness, injury or condition that led to the admission.

Out-of-State hospital providers must meet all requirements outlined in Chapter I of the MaineCare Benefits Manual (MBM) including signing a provider/supplier agreement and obtaining prior authorization. Hospitals are also subject to requirements outlined in MBM Chapter II, Section 45, Hospital Services and Section 46, Psychiatric Facility Services, as applicable.

Effective 5/23/09 45.09

CLINICAL LABORATORY AND RADIOLOGY SERVICES

Hospital laboratory services provided to a member not currently a patient of the hospital are considered outpatient hospital services and are reimbursable in accordance with MBM Chapter II, Section 55, Laboratory Services, or Chapter III, Section 90, Physician Services.

In the case of tissues, blood samples or specimens taken by personnel that are not employed by the hospital but are sent to a hospital for performance of tests, the tests are not considered outpatient hospital services since the member does not receive services directly from the hospital.

Certain clinical diagnostic laboratory tests must be performed by a physician and are, therefore, exempt from the fee schedule. Medicare periodically sends updated lists of exempted tests to hospitals.

Laboratory services must comply with the rules implementing the Clinical Laboratory Improvement Amendments (CLIA 88) and any applicable amendments. Hospital imaging services provided to a member not currently a patient of the hospital are considered outpatient hospital services and are reimbursable in accordance with MBM Chapter II, Section 101, Medical Imaging Services, or Chapter III, Section 90, Physician Services. Rates for those services are posted on the Department's designated website.

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5/23/09		

45.010 DISPROPORTIONATE SHARE (DSH) PAYMENTS

45.10-1 General Eligibility Requirements for DSH Payments

To be eligible for DSH payments a hospital must have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the State Plan. In the case of a hospital located in a rural area that is an area outside of a Metropolitan Statistical Area as defined by the Executive Office of Management and Budget, the term obstetrician includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

However, the obstetric criteria above, do not apply to hospitals in which the inpatients are predominantly individuals under eighteen (18) years of age or to hospitals that did not offer non-emergency obstetric services as of December 21, 1987.

The hospital must also have a MaineCare utilization rate of at least one percent (1%). Acute care hospitals must also meet additional requirements as described below.

Effective 5/23/09

45.10-2 Additional Eligibility Requirements for Acute Care Hospitals

The hospital must also either a) have a MaineCare inpatient utilization rate at least one (1) standard deviation above the mean MaineCare inpatient utilization rate for hospitals receiving MaineCare payments in the state), or b) have a low income inpatient utilization rate), exceeding twenty-five percent (25%).

For purposes of determining whether a hospital is a disproportionate share hospital in a Payment Year the Department will use data from the hospital's Medicare interim Cost Report for the same period to apply the standard deviation test. Interim Cost Settlement Reports for the specified payment year must be issued by the Department for all acute care hospitals in order for DSH to be calculated by the Department.

Effective 5/23/09

45.10-3 Disproportionate Share Payments

A. DSH Adjustment for Institutions for Mental Disease

Subject to the CMS IMD Cap described below and to the extent allowed by the Centers for Medicare and Medicaid Services (CMS), the DSH adjustment will be one hundred percent (100%) of the actual uncompensated cost, as calculated using Medicare Cost Report and GAAP principles, of:

- 1. services furnished to MaineCare members plus,
- 2. charity care as reported on the hospital's audited financial statement for the relevant payment year, MINUS

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45.10 DISPROPORTIONATE SHARE (DSH) PAYMENTS (cont)

3. payments made by the State for services furnished to MaineCare members.

CMS places a limit on the amount of DSH payment that may be made to IMDs (IMD cap). If the Department determines that aggregate payments to IMDs, as calculated above, would exceed the CMS IMD cap, payments will be made to State-owned facilities first. Remaining IMD DSH payments will be allocated among the DSH eligible hospitals based on their relative share of applicable DSH payments absent the federal or state cap.

The "relative share" is calculated as follows: calculate the fraction, the numerator of which is 100% of actual uncompensated cost of a non-state owned IMD, the denominator of which is the total of 100% of actual uncompensated cost for all non-state owned IMDs. That fraction is then multiplied by the remaining available for IMD DSH payments, as described above, to give the relative share for each non-state-owned IMD.

B. For Acute Care Hospitals

Effective 5/23/09

- 1. The pool of available funds for DSH adjustments for all acute care hospitals equals two hundred thousand dollars (\$200,000) for each State fiscal year.
- 2. Fifty percent (50%) of this pool will be distributed among eligible hospitals in proportion to their relative share of MaineCare days of all eligible acute care hospitals. Relative share will be calculated as follows: the MaineCare days for each DSH eligible hospital will be divided by the sum of the MaineCare days for all DSH eligible hospitals to determine the DSH allocation percentage. This DSH

allocation percentage for each eligible hospital will be multiplied by one hundred thousand dollars (\$100,000) to determine each eligible hospital's share.

For example:

Hospitals X, Y and Z are all eligible for DSH. MaineCare days for X equals five thousand (5,000); Y equals ten thousand (10,000) and Z equals fifteen thousand (15,000). The resulting total MaineCare days for DSH eligible hospitals would be thirty thousand (30,000) (5,000+10,000+15,000). Hospital X's DSH allocation percentage would be sixteen and seven tenths percent (16.7%) (5,000/30,000). Hospital X would get sixteen thousand seven hundred dollars

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45.10 **DISPROPORTIONATE SHARE (DSH) PAYMENTS (cont.)**

5/23/09

\$16,700) (\$100,000 times 16.7%) in DSH payments related to utilization.

3. Fifty percent (50%) of this pool will be distributed among eligible hospitals in proportion to the percentage by which the hospital's MaineCare utilization rate as defined above, exceeds one standard deviation above the mean. The percentage points above the first standard deviation for each DSH eligible hospital will be divided by the sum of the percentage points above the standard deviation for all acute care eligible hospitals to determine the DSH allocation percentage.

This standard deviation related DSH allocation percentage for each eligible acute care hospital will be multiplied by one hundred thousand dollars (\$100,000) to determine each hospital's share of the DSH payments.

For example:

Assume the same three hospitals, X, Y and Z, are all eligible for DSH. Respectively, their utilization rates are 6, 7 and 8 percentage points above the mean MUR plus one standard deviation. The resulting total percentage points above the mean for all hospitals would be 21 (6+7+8). Hospital X's DSH allocation percentage would be twenty-eight and fifty-seven hundredths (28.57%) (6/21). If fifty percent (50%) of the available DSH pool is one hundred thousand dollars (\$100,000), then Hospital X would get twenty eight thousand five hundred and seventy thousand dollars (\$28,570) (\$100,000 times 28.57%) in DSH payments related to distance above one standard deviation above the mean.

After final settlement is complete for all hospitals in a category (i.e., acute care or psychiatric) hospitals within the category are assessed for eligibility for DSH payments. However, state psychiatric hospitals only may be paid DSH as part of a prospective interim payment if they are expected to be found eligible.

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Effective 5/23/09

Appendix A

1. General Inpatient

The hospital specific rate per Medicaid discharge is determined by:

- a. Determining a cost per Medicaid discharge based on Medicare cost reports for each hospital's fiscal year beginning between October 1, 1998 and September 30, 1999;
- b. Inflating this cost per discharge to State fiscal year 2004; and
- c. Adjusting rates down by 1.3785 percent. For services rendered on or after July 1, 2005 this rate will be increased by 2.47%.
- d. As of August 1, 2006 per discharge payments are reduced by 13.38%.
- e. These rates will be adjusted annually for inflation at the beginning of the State fiscal year as described in 45.02-1.

2. Distinct Psychiatric Unit Inpatient

Effective August 1, 2006, discharges from distinct psychiatric units will be reimbursed at \$6053.27 per discharge except for Northern Maine Medical for which the per discharge rate will be \$14,741.28. These rates will be adjusted annually for inflation as described in 45.02-1.

Discharge Rates

Effective 8/1/06

Effective 5/23/09

Hospital	Acute Care Discharge Rate	Psych Unit Rate
Non-Critical Access Hospitals		
Cary Medical Center	\$2,793.90	NA
Central Maine Medical Center	\$5,056.52	NA
Eastern Maine Medical Center	\$6,480.84	NA
Franklin Memorial*	\$2,651.47	NA
Henrietta D Goodall	\$3,202.23	NA
Inland Hospital	\$2,821.45	NA
Maine Coast Memorial	\$3,062.00	NA
MaineGeneral Health	\$4,343.77	\$6,053.27
Maine Medical Center	\$6,579.67	\$6,053.27
Mercy (inc Westbrook)	\$,3,712.39	NA
Mid Coast Hospital	\$3,093.75	\$6,053.27
Miles Memorial	\$2,940.97	NA
New England Rehab	\$12,535.59	NA
Northern Maine	\$3,457.00	\$14,741.28
Parkview Memorial	\$2,588.30	NA
Penobscot Bay	\$3,657.24	\$6,053.27

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	Saint Joseph's	\$5,928.39	NA
	Saint Mary's	\$5,944.61	\$6,053.27
	Southern Maine Medical Center	\$3,617.07	\$6,053.27
ve	Stephens Memorial	\$2,385.72	NA
/e	The Aroostook Medical Center	\$3,685.49	\$6,053.27

Effective 5/23/09

^{*}Note: Franklin Memorial hospital services rate was changed due to a revision made to the base year report.